PATIENT MEDICAL HISTORY

Name:	Date of birth:				
Although dental personnel primarily treat the area in and ar body. Health problems that you may have, or medication interrelationship with the dentistry you will receive. Th	n that you may b	e taking, could have an	ímportant		
Are you under a physician's care now?	□Yes □No	If yes, Specify:			
Have you ever been hospitalized or had a major operation?	□Yes □No	If yes, Specify:			
Have you ever had a serious head or neck injury?	□Yes □No	If yes, Specify:			
Are you taking any medications, pills, or drugs?	□Yes □No	If yes, Specify:			
Do you take, or have you taken, Phen-Fen or Redux?	□Yes □No	If yes, Specify:			
Do you use tobacco?	□Yes □No	If yes, Specify:			
Do you use controlled substances?	□Yes □No	If yes, Specify:			
Have you ever taken Fosamax, Boniva, Actonel or any other m	edications conta	ining bisphosphonates?	□Yes □No		
Do You Snore? / Trouble Sleeping? / Tired During the Day? / I	Restless Leg Syn	drome/ Use CPAP?	□Yes □No		
Taking oral contraceptives? □Y	Yes □No Yes □No Yes □No				
*Are you allergic to any of the following? Aspirin Penicillin Codeine Local And Latex Sulfa Drugs Other If yes, exp	lain:				
If answer was yes for premed, please list reason why	:				
PREFERRED PHARMACY:					

PATIENT MEDICAL HISTORY

Do you have, or have you	ı had, any of	f the following:				
Aids/HIV Positive	□Yes □	lNo	Hepatitis A	□Yes	□No	
Alzheimer's Disease		lNo	Hepatitis B or C	□Yes	□No	
Anaphylaxis		lNo	Herpes	□Yes	□No	
Anemia	□Yes □	No	High Blood Pressure	□Yes	□No	
Angina	□Yes □	No	High Cholesterol	□Yes	□No	
Arthritis/Gout	□Yes □	No	Hives or Rash	□Yes	□No	
Artificial Heart Valve	□Yes □	lNo	Hypoglycemia	□Yes	□No	
Artificial Joint	\square Yes \square	lNo	Irregular Heartbeat	□Yes	□No	
Asthma	\square Yes \square	No	Joint replacement or implant	□Yes	□No	
Blood Disease	\square Yes \square	No	Kidney Problems	□Yes	□No	
Blood Transfusion	\square Yes \square	No	Leukemia	□Yes	□No	
Breathing Problem	\square Yes \square	No	Liver Disease	□Yes	□No	
Bruise Easily		lNo	Low Blood Pressure	□Yes	□No	
Cancer		lNo	Lung Disease	□Yes	□No	
Chemotherapy		lNo	Mitral Valve Prolapse	□Yes	□No	
Chest Pains		No	Osteoporosis	□Yes	□No	
Cortisone Medicine		No	Pain in Jaw Joints	□Yes	□No	
Cold Sores/Fever Blisters		lNo	Parathyroid Disease	□Yes	□No	
Congenital Heart Disorder		lNo	Psychiatric Care	□Yes	□No	
Convulsions		lNo	Radiation Treatment	□Yes	□No	
Diabetes		lNo	Recent Weight Loss	□Yes	□No	
Drug Addiction		lNo	Renal Dialysis	□Yes	□No	
Easily Winded		lNo	Rheumatic Fever	□Yes	□No	
Emphysema		lNo	Rheumatism	□Yes	□No	
Epilepsy English Planting		lNo	Scarlet Fever	□Yes	□No	
Excessive Bleeding		lNo	Seizures	□Yes	□No	
Fainting Spells/Dizziness		lNo	Sinus Trouble	□Yes	□No □No	
Frequent Cough		lNo lNo	Spina Bifida Stomach/Intestinal Disease	□Yes □Yes	□No	
Frequent Diarrhea Frequent Headaches		lNo	Stroke	□Yes	□No	
Genital Herpes		lNo	Swelling of Limbs	□Yes	□No	
Glaucoma		lNo	Thyroid Disease	□Yes	□No	
Hay Fever		lNo	Tonsillitis		□No	
Heart Attack/Failure	□Yes □		Tuberculosis	□Yes		
Heart Murmur	□Yes □		Tumors or Growths	□Yes		
Heart Pace Maker	□Yes □		Ulcers	□Yes		
Heart Trouble/Disease	□Yes □		Venereal Disease	□Yes		
Hemophilia	□Yes □		Venereal Discuse	— 105	— 110	
Have you ever had any serious illness not listed above? ☐Yes ☐No If yes, please explain:						
■ I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I understand the above information, and guarantee this form was completed correctly to the best of my knowledge an understand it is my responsibility to inform this office of any changes to the information I have provided.						
Print Name	Print Name Signature					
Date						
Doctor SignatureDate						

NAME	PATIENT INFORMATION (CONFIDENT	ΠAL)			·	
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RELATIONSHIP TO PATIENT BIRTHDATE SS#/SIN DATE EMPLOYED NAME OF EMPLOYER UNION OR LOCAL # WORK PHONE STATE/ ZIP/ PROV. P.C. INSURANCE CO. TEL. # GRP # POLICY / I.D. # STATE/ STATE/ ZIP/ PROV. P.C. INS. CO. ADDRESS CITY PROV. P.C.	HOW MUCH IS YOUR DEDUCTIBLE? HOW MUCH HAVE YOU USED? MAX ANNUAL BENEFIT?					
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BIRTHDATE SS#/SIN DATE EMPLOYED NAME OF EMPLOYER UNION OR LOCAL # WORK PHONE STATE/ ZIP/ PROV. P.C. INSURANCE CO. TEL. # GRP # POLICY / 1.D. # STATE/ ZIP/ PROV. P.C. INS. CO. ADDRESS CITY PROV. P.C.			k je popovila amendo kimili kuri bilo da monikini sema adli da mudikini da kori		on commence of the commence of	
NAME OF EMPLOYER UNION OR LOCAL # WORK PHONE STATE/ PROV. P.C. INSURANCE CO. IEL. # GRP # OUICY / I.D. # STATE/ STATE/ PROV. P.C. ZIP/ PROV. P.C.						
INSURANCE CO. TEL. # GRP # POLICY / I.D. # INS. CO. ADDRESS CITY STATE/PROV. P.C.						
INSURANCE CO. TEL. # GRP # POLICY / I.D. # INS. CO. ADDRESS CITY STATE/PROV. P.C.				WORK PHONE STATE/	ZIP/	
	INSURANCE CO TEL. #	GRP #		POLICY / I.D. #	71D/	
HOW MUCH IS YOUR DEDUCTIBLE? HOW MUCH HAVE YOU USED? MAX ANNUAL BENEFIT?	INS. CO. ADDRESS	CITY		PROV.	P.C.	
	HOW MUCH IS YOUR DEDUCTIBLE? HOW	MUCH HAVE YOU USED?		MAX ANNUAL B	ENEFIT?	

X
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT NUMBER